

Issue Brief: Freestanding Emergency Departments

Introduction

CHA and its member hospitals and health systems have long been supportive of increased health care access and transparency in Colorado. To this end, the Association actively supports efforts such as the hospital report card and the all-payer claims database to help provide consumers with better information so that they may make informed choices about their health care.

Freestanding emergency departments (FSEDs), and similar facilities often confused with FSEDs, have been the subject of significant media coverage in recent years, highlighting concerns of the public, consumer advocates and state legislators. These include perceived lack of price transparency, patients' inability to discern between conditions needing immediate emergency treatment and those needing care at more appropriate alternative settings, and patients' lack of understanding that they are receiving care in an emergency department and the financial consequences of that decision. Appendix A contains a more thorough assessment of the pros and cons of the FSED model.

In response to these community concerns, the Association convened a task force in late 2015 to examine these facilities and develop best practices for hospitals and systems to use in better educating health care consumers about the rapidly-evolving health care system in Colorado. The task force recommended, and CHA's Board of Trustees subsequently adopted, a series of guiding principles for FSEDs, which are detailed in Part 3 below.

- Part 1: Understanding FSEDs: History, Structure, Applicable Law
- Part 2: Key Legal Considerations: EMTALA
- Part 3: CHA Policy Principles
- Appendix A: Pros & Cons of the FSED Model
- Appendix B: Additional Resources & Articles of Interest

Colorado's first legislative attempts to address FSED-related issues occurred in 2014. In 2016, a legislative effort sought to require additional signage and consumer education in FSEDs, but the effort failed. In recent legislative stakeholder meetings, key issues identified surrounding FSEDs included consumer confusion about services and cost, as well as concerns with rapid growth, particularly into suburban areas.

This document is intended to provide background and summary information to interested stakeholders around the current operation and regulatory structure within which FSEDs operate.

Part 1: Understanding FSEDs: History, Structure, Applicable Law

FSEDs were first created in the 1970s to fill a need for emergency care in rural and underserved areas that otherwise could not financially sustain an inpatient hospital. However, the recent growth in FSEDs has primarily been in urban and suburban areas. As of August 2016, CDPHE lists 39 facilities licensed as Community Emergency Centers (CECs, also called Community Clinics and Emergency Centers) on its website, located primarily – but not exclusively – in urban and suburban areas along the Front Range.¹ FSEDs are distinguished from free-standing urgent care centers in that they provide a higher level of care and can handle more acute conditions.

Nationally, hospital-affiliated FSEDs increased 76 percent between 2008 and 2015 to 387, operated by 323 different hospitals. The majority are currently located in Texas, Colorado and Arizona. The 172 independently-owned FSEDs are owned by 17 different for-profit entities; 90 percent are located in Texas, with the others in Colorado and Arizona.²

FSEDs can be hospital-owned-and-operated, hospital-affiliated, or owned by a company independent of a hospital or health system. This operational distinction is important because it affects federal regulation, state licensure, and reimbursement. As of August 2016, all of Colorado's operating FSEDs are either hospital owned or affiliated. However, at least one non-hospital-affiliated company intends to open multiple Colorado locations in or before the fourth quarter of 2016.³

- **Hospital-owned-and-operated FSEDs** are generally licensed by the state as CECs, although they can also be licensed as hospitals. Under federal law, they operate as provider-based off-campus emergency departments of a parent hospital and are subject to all of the Medicare Conditions of Participation (CoP)⁴ and EMTALA requirements (see Part 2 below).^{5,6,7} These facilities can bill Medicare and Medicaid for services rendered, as well as facility fees under the parent hospital's tax identification number.
- **Independent FSEDs** are not owned or operated by a hospital or health system that includes licensed Colorado hospitals. Because these facilities do not meet the federal statutory definition of a hospital, they cannot bill Medicare or Medicaid for emergency

¹ <https://www.colorado.gov/pacific/cdphe/community-clinic-consumer-resources>

² <http://www.medpac.gov/documents/september-2015-meeting-presentation-emergency-department-services-provided-at-stand-alone-facilities.pdf?sfvrsn=0>

³ Neighbors Health System is set to open a new, independent FSED in 2016.

<http://www.greeleytribune.com/news/20666296-113/the-health-care-paradox-northern-colorado-companies-build#>

⁴ 42 CFR 482.1 through 482.57

⁵ 42 CFR 489.24 (d) (4) (ii)

⁶ 42 CFR 489.24 (d) (4) (iv)

⁷ CMS EMTALA Interpretive Guidelines, State Operations Manual Appendix V

services rendered or facility fees. In Colorado, these facilities are regulated under state EMTALA look-alike rules,^{8,9} but federal EMTALA rules do not apply.

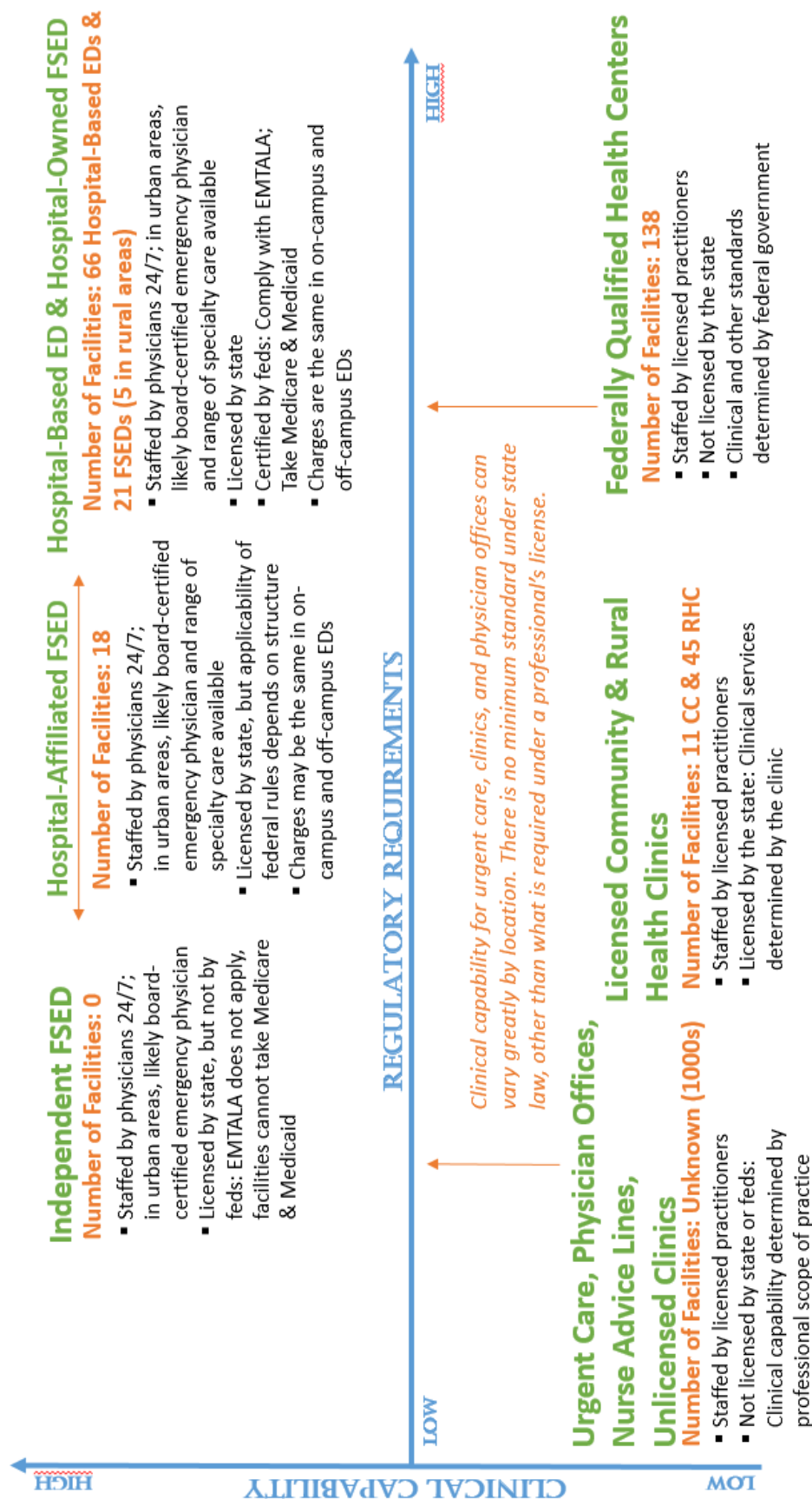
- ***Hospital-affiliated FSEDs*** are independent FSEDs that have developed non-ownership relationships with health systems and use the health system's brand. In these situations, facilities are licensed by the state, but because they are not hospital-operated off-campus emergency departments, they may not bill Medicare or Medicaid, and EMTALA does not apply. However, as of August 2016, all hospital-affiliated FSEDs not subject to federal law are voluntarily complying with EMTALA and accepting Medicare and Medicaid patients (although not billing for them).

The graphic on the following page summarizes the regulatory requirements and clinical capabilities of FSEDs as compared to other facility types, and shows that facilities commonly referred to as FSEDs fall into three categories, but are all licensed by CDPHE as CECs.

However, note that some facilities publically-perceived as FSEDs could be licensed as a hospital, and thus would fall within the "hospital-based" ED category.

⁸ 6CCR 1011-1 Chapter 9 Part 18.102(2) requires CECs to develop policies for processing patients presenting for emergency services including procedures for initial assessment, prioritization for medical screening and treatment, and patient reassessment and monitoring. All patients presenting for emergency services must be provided with a medical screening before inquiring about payment or insurance.

⁹ 6CCR 1011-1 Chapter 9 Part 6.102(3) requires CECs establish a transfer plan that includes agreements with at least one hospital that includes procedures for obtaining air or ground transportation, transfer protocols that include coordination with the local EMS system and licensed ambulance services in the case of medically necessary transfers, triage and stabilization by on-duty staff, and the transfer of relevant patient information with the patient.



Numbers as of 8/29/2016

Part 2: Key Legal Considerations: EMTALA

For facilities that must maintain compliance with EMTALA (the Emergency Medical Treatment and Labor Act) – including hospital-based EDs, hospital-owned FSEDs, and hospital-affiliated FSEDs that voluntarily comply with EMTALA as a matter of policy – this federal law is a significant consideration when evaluating any proposed policy changes. Of note, facilities licensed by the state as CECs must abide by the state’s “EMTALA look-alike” regulations, also discussed below.

Information below explains the history, requirements, and application of EMTALA, as well as the application of Colorado’s EMTALA look-alike rules.

EMTALA History

EMTALA is a federal law passed in 1985 in response to perceptions that emergency departments were inappropriately denying care to patients, also referred to at the time as “patient dumping.” In brief, EMTALA requires stabilizing care be provided to all individuals that present at an emergency department if, after a medical screening exam is conducted, they have an emergency medical condition. Severe limitations exist – and heavy penalties may be imposed – for any barriers to care (e.g., screening for ability to pay) that are imposed on the patient before the emergency condition is stabilized. Therefore, hospitals are hesitant to create any disincentives or perceived barriers to receiving stabilizing care.

The penalty for an EMTALA violation includes a fine of \$50,000 for both the hospital and the treating clinician. Multiple violations can result in disqualification from participating in Medicare and Medicaid and loss of eligibility for Medicare value-based purchasing, which would severely impact the financial viability of any hospital.

Relevant EMTALA Regulatory Language

Prior proposals to create notification programs in FSEDs could have resulted in conflicts with the application of EMTALA. The following language from federal regulations and sub-regulatory guidance may be a helpful guide to crafting any new proposals:

“A participating **hospital may not seek...authorization** from the individual's insurance company **for screening or stabilization...** [provided] to an individual until **after** the hospital has provided the appropriate medical screening examination... and initiated any further medical examination and treatment that may be required to stabilize the emergency medical ...”¹⁰

“Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. **Reasonable registration**

¹⁰ 42 CFR 489.24 (d) (4) (ii)

processes may not unduly discourage individuals from remaining for further evaluation.”¹¹

“If an individual leaves a hospital Against Medical Advice (AMA) or LWBS, on his or her own free will (**no coercion or suggestion**) the hospital is not in violation of EMTALA.”¹²

Although each of these provisions is seemingly simple in isolation, there is a body of complex case law based on the regulations and interpretive guidelines that more thoroughly define obligations and restrictions.

As patient notification via posted signage has been a common proposal in prior years, CHA researched EMTALA issues related to signage. In 2012 and 2013 after South Carolina hospitals began using signage to educate the public about the prescription opioid epidemic and prescribing protocols in South Carolina hospitals.¹³ Concerned about the potential EMTALA conflict, the CMS Region IV office issued a letter¹⁴ to the South Carolina Hospital Association finding, among other things, that the signage may discourage patients from seeking a screening exam and would be seen as an EMTALA violation an hospitals could be cited. This ruling has since been upheld by at least one other regional CMS office.¹⁵

Similarly, CHA has heard from member hospitals across Colorado that state surveyors from CDPHE have indicated that hospitals have been warned that signage regarding potential co-pays, types of insurance that are accepted, and potential non-emergency charges would be seen as EMTALA violations. This appears to be consistent with previous rulings and citations from CMS nationally.¹⁶

Application of Colorado’s “EMTALA Look-Alike” Rules

Hospital owned-and-operated FSEDs are subject to EMTALA and the Medicare CoP.¹⁷ Those FSEDs are also regulated by state EMATLA look-alike rules enforced by CDPHE, which apply to all licensed CECs, including hospital-affiliated and independent FSEDs not subject to federal law.¹⁸

The state regulations require CECs to develop policies for processing patients presenting for emergency services including procedures for initial assessment, prioritization for medical

¹¹ 42 CFR 489.24 (d) (4) (iv)

¹² CMS EMTALA Interpretive Guidelines, State Operations Manual Appendix V

¹³ Retrieved February 14, 2016 from: <http://www.acepnow.com/article/ed-waiting-room-posters-prescribing-pain-medications-may-violate-emtala/>

¹⁴ CMS Letter to South Carolina Hospital Association dated February 6, 2013. Retrieved February 14, 2016 from: <http://www.acep.org/workarea/DownloadAsset.aspx?id=101750>

¹⁵ Ohio Hospital Association EMTALA ruling. Retrieved February 14, 2016 from: http://www.ohioafp.org/wp-content/uploads/OHA_Memo_on_Emergency_Department_Opiate_Prescribing_Guidelines.pdf

¹⁶ The Wrong Writing on the Wall. *Emergency Physicians Monthly*. Retrieved February 14, 2016 from: <http://epmonthly.com/article/the-wrong-writing-on-the-wall/>

¹⁷ 42 CFR 482.1 through 482.45

¹⁸ 6CCR 1011-1 Chapter 9 18.102(2)

screening and treatment, and patient reassessment and monitoring. **All patients presenting for emergency services must be provided with a medical screening before inquiring about payment or insurance.**

In addition, CECs must establish a transfer plan that includes agreements with at least one hospital that includes procedures for obtaining air or ground transportation, transfer protocols that include coordination with the local EMS system and licensed ambulance services in the case of medically necessary transfers, triage and stabilization by on-duty staff, and the transfer of relevant patient information with the patient.¹⁹

Following the medical screening evaluation and prior to initiation of care or treatment, **patients may request the estimated average charge for non-emergent care.** This includes reasonable assistance with determining the charges which may include deductibles and co-payments that would not be covered by a third-party payer based on the coverage information supplied by the patient or patient designated representative.²⁰

Part 3: CHA Policy Principles

CHA is supportive of increasing consumer education and transparency to improve patient decision-making. As such, the Association established a member task force in late 2015 to develop best practices that could be applied to FSEDs. In March 2016, CHA's Board of Trustees adopted a policy statement that included the following:

Over-Arching Principles

- Hospitals and health systems have a responsibility to provide fair, timely and appropriate communications with patients regarding potential health care costs to the consumer.
- Consumers should be able to access health care services of choice without barriers or restrictions, as long as they are notified of potential financial consequences. However, the emergency department is not a substitute for primary care, and patients with non-emergent conditions are better served in the primary care setting.
- Information provided for the purpose of consumer education should not be used to dissuade patients from accessing the care they need when they need it.

Operation of FSEDs

- All freestanding emergency departments should be clearly identified through prominent, lighted, external signage that includes the word "emergency."
- Independent FSEDs that have an affiliation with a hospital or health system – or hold themselves out as being affiliated – should adhere to the requirements of EMTALA.

¹⁹ 6CCR 1011-1 Chapter 9 6.102(3)

²⁰ 6CCR 1011-1 Chapter 2 6.104

- Hospitals and health systems that own or are affiliated with FSEDs should consider models of care that provide patients with the appropriate level of care and bill accordingly, which often may be unrelated to the presenting medical problem.
- As soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized, all emergency departments, including FSEDs, should provide every patient²¹ with the following information in an EMTALA-compliant manner:
 - Notification that he or she is receiving services in an outpatient emergency department of the hospital;
 - Notification that the treating clinician may be outside of their insurance network and could result in higher fees;
 - A statement that patients are encouraged to contact their insurer for information about what the insurance policy covers and the patient's potential out-of-pocket expenses for any services provided.
- Future growth of FSEDs should consider the needs of underserved areas as a strategy to address long-standing issues of access to acute and primary care.

Consumer Education & Public Policy

- CHA will work with hospitals, health systems and FSEDs to create a consumer-focused education campaign (i.e., primary care vs. urgent care vs. ED) including, but not limited to: Public Service Announcements (PSAs), media relations campaign, social media messaging, and a website and digital presence.
- CHA will work with policy makers and regulatory agencies to ensure that any state-level legislative or regulatory policy solutions comply with all federal regulations such as EMTALA and other licensing requirements.

In addition to this FSED-specific policy, CHA is committed to solutions that ensure an even playing field and policy consistency across facility types, as well as efforts that align with existing federal and state legal obligations.

²¹ Except those patients covered by Medicaid or Workers' Compensation, who are not subject to insurance co-pays.

Appendix A: Pros & Cons of the FSED Model

The New York State Department of Health recently released an overview document as the state considers how to address the rise of FSEDs nationally. Included in that document is “Assets and Liabilities of the [FSED]²² Model,” which has been adapted into the following chart.²³ This chart reflects common themes found in research on FSEDs. As health care leaders consider possible actions to shape this rapidly developing segment of the health care market in Colorado, this chart can be helpful in identifying strengths and weaknesses of the FSED model.

Pros	Cons
<ul style="list-style-type: none"> Increases the availability of high-quality emergency care in more convenient and readily accessible settings. Can relieve overcrowding of hospital-based emergency departments. Operate with faster throughput, resulting in reduced patient wait times and increased patient satisfaction. More economical and efficient than constructing new hospitals to fill health care voids in under-served regions Some private insurers have created reimbursement schedules for FSEDs or have entered into contracts with FSEDs to structure and reduce costs. Rapid growth and success experienced in other states. 	<ul style="list-style-type: none"> More expensive than urgent care. FSEDs treat many lower acuity patients who may have otherwise been seen by a primary care physician or urgent care at significantly lower cost. FSEDs can also charge a facility fee, increasing costs to insurers or passed along to patients. Private insurers have sued FSEDs to reduce costs. Overlap in scope of services with urgent care centers and hospital-based EDs can lead to consumer confusion about appropriate use. FSEDs are not equipped to handle all trauma care, and some do not have on-call specialists. Patients who require hospital admission and, in some instances, surgery or specialist care, must be transferred to a higher-acuity facility and EMS transport protocols are needed to ensure prompt inter-facility transport. Concerns about access to care and availability of emergency services when FSED operates less than 24/7.²⁴ Patient over-reliance on FSED may undermine relationship with primary care physician or patient medical home. FSEDs are increasingly being built in locations to muscle in on a competing hospital's ED and siphon off its patients even if there are adequate emergency services nearby. Concerns have been raised about whether the duplication of personnel and equipment between the acute care hospital and the freestanding emergency room is a good thing for a healthcare delivery system already facing severe expense pressures. Minimal academic study confirming quality and effectiveness.

²² The State of New York uses the Acronym FED for freestanding emergency department. It has been changed for consistency in CHA's issue brief.

²³ http://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-09-13/docs/feds_background.pdf

²⁴ All FSEDs in Colorado operate 24 hours, seven days a week.

Appendix B: Additional Resources & Articles of Interest

- Survey of Patient Knowledge and Expectations about a Free-Standing Emergency Department – *Advances in Emergency Medicine*
<http://downloads.hindawi.com/journals/aem/2015/867094.pdf>
- Free Standing Emergency Departments – New York State Department of Health
http://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-09-13/docs/feds_background.pdf
- Estimated Costs of Rural Freestanding Emergency Departments
<https://www.ruralhealthresearch.org/alerts/101>
- Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities – Maryland Health Care Commission
http://mhcc.maryland.gov/mhcc/pages/plr/plr_hospital/documents/chcf_fmf_report_final_ltr_20150204.pdf
- MEDPAC Presentation, September 11, 2015: Emergency department services provided at stand-alone facilities
<http://www.medpac.gov/documents/september-2015-meeting-presentation-emergency-department-services-provided-at-stand-alone-facilities.pdf?sfvrsn=0>
- Dissecting the Cost of a Freestanding Emergency Department Visit – Urgent Care Association of America
http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Alan_Ayers_Blog/UCAOA_Ayers_Blog_FSED_Pricin.pdf
- Freestanding Emergency Departments and the Trauma Patient – *Journal of Emergency Medicine*
https://www.researchgate.net/profile/Erin_Simon/publication/269179652_Freestanding_Emergency_Departments_and_the_Trauma_Patient/links/54a30a7c0cf257a63604ddd2.pdf
- Freestanding Emergency Departments: An Information Paper – American College of Emergency Physicians
https://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/administration/Freestanding%20Emergency%20Departments%200713.pdf
- Free-standing ERs abound in affluent Colorado neighborhoods – *The Denver Post*, September 25, 2015
http://www.denverpost.com/news/ci_28874739/freestanding-ers-abound-affluent-colorado-neighborhoods
- Buyer beware: Freestanding emergency rooms – 9News, November 16, 2015
<http://bcove.me/haav8gat>
- Confusion about free-standing ER brings Colorado mom \$5,000 bill – *The Denver Post*, October 31, 2015
http://www.denverpost.com/news/ci_29050451/confusion-about-free-standing-er-brings-colorado-mom
- Centura Health to open hybrid ER/urgent-care centers – *Modern Healthcare*, November 11, 2015
<http://www.modernhealthcare.com/article/20151111/NEWS/151119995>

- Emergency Care, But Not At A Hospital – Kaiser Health News, May 31, 2011
<http://khn.org/news/michelle-andrews-on-hospital-er-alternatives/>
- Who needs beds? New ambulatory centers offer everything except inpatient care – *Modern Healthcare*, September 12, 2015
<http://www.modernhealthcare.com/article/20150912/MAGAZINE/309129973/who-needs-beds-new-ambulatory-centers-offer-everything-except>
- Top 10 Factors to Consider When Building a Freestanding Emergency Department – *Becker's Hospital Review*, March 19, 2014
<http://www.beckershospitalreview.com/patient-flow/top-10-factors-to-consider-when-building-a-freestanding-emergency-department.html>
- Free-standing ERs eye lobbying to win state approval for growth – *Modern Healthcare*, July 4, 2015
<http://www.modernhealthcare.com/article/20150704/MAGAZINE/307049969>